TRANSITIONAL CARE UNIT (TCU)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available information, Plan expectations, your contract, and MassHealth guidance. This information should be materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

The Transitional Care Unit (TCU) is designed for youth who are in the care or custody of the Department of Children and Families (DCF) who have been referred directly from DCF. Enrollees who require this setting are expected to return home with parents/caregivers, foster care, community-based group home, or long-term residential treatment, and no longer meet medical necessity criteria for continued stay at an inpatient or Intensive Community-Based Acute Treatment or Community-Based Acute Treatment (ICBAT/CBAT) level of care. TCUs are provided in an environment that is less restrictive than inpatient and ICBAT/CBAT and more structured than partial hospitalization or outpatient treatment. TCUs are solely intended to meet the needs of youth who are ready to leave an acute inpatient setting or ICBAT/CBAT; priority is given to youth in inpatient settings. The length of stay in this type of treatment setting is no longer than 30 days. Transitional Care Services are designed to facilitate transition to the youth's next placement setting through comprehensive transition planning and medically necessary behavioral health services.

SERVICE COMPONENTS

1. TCU providers maintain all required licenses and specifically adhere to the Department of Early Education and Care (EEC) licensure requirements for community-based programs.
2. Transitional Care Unit services include but are not limited to:
    a) A comprehensive assessment including the MA Child and Adolescent Needs and Strengths (CANS) completed by a (CANS) certified clinician, as part of discharge

planning to determine the youth's functioning and need for medical, educational, functional, behavioral health and other supports.

b) Substance use evaluation
c) Development of treatment plan and review of treatment/transition plans to include discharge plans
d) Development and review of risk management/safety plans
e) Individual therapy
f) Family Therapy
g) Group therapy
h) Trauma-informed assessment and treatment
i) Medication management
j) Crisis Management
k) Identification and facilitation of medically necessary consultation services
l) Convening and facilitating treatment (Family Team) meetings
m) Ongoing, daily contact with parent/caregiver, or less frequent as determined by DCF
n) Ongoing minimum weekly contact with DCF and collateral service providers

3. Provider communicates and collaborates with DCF to coordinate all routine and necessary medical and dental care.

STAFFING REQUIREMENTS

1. Admissions to TCU are accepted during business hours five (5) days per week.
2. The provider ensures 24 hour staffing, seven (7) days per week, 365 days a year, including awake, supportive overnight staff.
3. The provider ensures that a master's level child-trained clinician is assigned to each youth entering the program. Master's level clinicians must be on site during business hours and available 24 hours per day, seven (7) days per week to meet the clinical and care coordination needs of youth in the program.
4. The provider ensures adequate staffing of master's level clinicians certified to administer the MA Child and Adolescent Needs and Strengths (CANS).
5. The provider ensures that a board-certified or board-eligible child psychiatrist or a child-trained APRN is available by phone, 24 hours per day, seven (7) days per week for consultation related to treatment planning and medication concerns.
6. The provider ensures that a senior level child-trained clinician is available for clinical consultation to staff between 8pm and 8am, seven (7) days per week, 365 days a year.
7. The provider ensures training for staff that includes initial and at least annual review on the following topics:
    a) DCF Specifications for Transitional Care Placement Services
    b) TCU performance standards and medical necessity criteria
    c) Medications and side effects
    d) First Aid/CPR

e) Child-serving systems and processes (e.g., DCF, DMH, DYS, DESE etc.)
f) *Systems of Care* philosophy and principles
g) Conflict resolution
h) Family Systems
i) Risk management/safety planning
j) Crisis Management
k) Trauma informed care
l) Child development
m) Cultural, linguistic, and socio-economic competency
n) Restraint reduction/elimination techniques

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The TCU provider maintains regular, ongoing contact with the Managed Care Entity (MCE) regarding census and availability including information regarding upcoming discharges. Planned discharges must be communicated to the MCE five (5) days in advance.
2. Youth referred to TCU must be in the care or custody of DCF. Referrals are made by the MCE or the DCF MHS:
    a) When the MCE identifies the eligible youth, based on medical necessity criteria, the MCE notifies the DCF MHS via fax on the same day to obtain consent for TCU. The DCF MHS responds via fax to the MCE with consent and identification of required geographic location of TCU within two (2) business days.
    b) When the DCF MHS identifies the eligible youth, based on the DCF disposition plan for youth, the MHS identifies the required geographic region and notifies the MCE via fax on the same day that approval has been obtained.
3. The MCE verifies medical necessity and identifies TCU placement. If TCU placement is not available, youth will be placed on Children Awaiting Resolution and Disposition (CARD) list until placement becomes available or alternative placement is identified by DCF. In either case, the MCE notifies the DCF MHS via fax within one (1) business day.
4. The MCE notifies the TCU provider to expect admission.
5. The TCU provider coordinates admissions with the referring facility and DCF MHS.
6. The TCU provider maintains regular, at a minimum weekly contact with DCF staff as appropriate for each youth in the program.
7. The TCU provider maintains linkages and working relationships with the local Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) provider in their service area to ensure care is properly coordinated for youth served by TCU who may require ESP/MCI. With consent from the parent/guardian/caregiver, if required, when a youth needs intervention from ESP/MCI, the TCU clinician is in contact with the ESP/MCI staff at the time of referral to provide relevant information regarding youth's functioning and crisis precipitants.
8. The TCU provider develops and documents organizational linkages with local agencies providing foster care services and community-based group homes to improve access to these services and develop and maintain smooth transition planning.

9. The TCU provider develops linkages and policies that promote communication and coordination of care with local PCCs/PCPs and pediatricians.
10. With consent from the legal guardian, the TCU provider communicates and collaborates with all necessary individuals involved with the youth (e.g., existing behavioral health providers, DCF workers, probation officers, guardian's ad litem, DYS staff, attorneys, LEA's, physicians, etc.) for the purpose of treatment, transition planning, and coordination of care.
11. The TCU clinician maintains regular, frequent contact with collateral service providers and state agencies by telephone invites them with adequate notice to transition/care planning meetings and, with consent, provides them with copies of the completed transition/care plan.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The TCU provider ensures that a master's level child trained clinician participates in the discharge-planning meeting at the sending facility to effect continuity of care for each youth that is referred.
2. The TCU provider contacts the parent/caregiver as determined by DCF within 24 hours of notification of pending admission by the MCE.
3. An initial assessment is completed upon admission.
4. An initial treatment/transition plan is completed within 24 hours of admission.
5. An initial risk management/safety plan must be completed within 24 hours of admission. If additional risk issues are identified after this initial period a risk management/safety plan should be completed immediately upon identification of these issues.
6. The APRN or child psychiatrist must meet and review the youth's psychiatric medications at minimum within five (5) business days of admission or sooner if indicated, and periodically thereafter for medication management purposes.
7. Consult with DCF within one business day of admission to identify Family Team and schedule a meeting to develop a comprehensive treatment/transition plan for the youth. This meeting occurs within five (5) days of admission to TCU.
8. The TCU provider coordinates care planning with all existing providers and state agency representatives and makes referrals for additional services as needed.
9. The treatment/transition plan considers educational, social/recreational, family/living, behavioral health/psychiatric and medical needs, the youth's current functioning efforts in locating and securing a placement resource and services needed to support transition. The plan includes documentation of increasing opportunities for the youth to spend time in the community.
10. A written treatment /transition plan is generated within one (1) business day of the treatment (Family Team) meeting. With consent, copies of the treatment/transition plan are distributed to all relevant collateral providers, parents/caregivers, and state agency representatives.
11. The provider schedules weekly treatment/transition planning meetings for each youth. The treatment/transition plan is updated following this meeting to reflect progress in locating and securing a placement resource and/or changes in the youth's functioning or needs.

12. All medically necessary consultation services will be arranged within one (1) business day of admission.
13. A written treatment plan outlines tasks to be accomplished in life domains and identifies individuals responsible for tasks.
14. All services and supports are carefully structured to achieve optimum results in the most time efficient manner possible;
15. There is documented active coordination of care with the youth's care manager, and/or other services and state agencies.

Discharge Planning and Documentation

1. Once a placement is identified the TCU provider:
    a) Works with DCF and/or the parents/caregivers, and youth to formulate a pre-placement visitation plan. The visitation plan affords opportunities to learn, practice and demonstrate new behaviors and patterns of interaction.
    b) Coordinates with DCF and/or the youth's legal guardian to ensure the youth is enrolled in the local school district where they will be residing.
    c) Makes referrals for all necessary supports and services identified in the youth's treatment plan in coordination with DCF.
2. A comprehensive assessment inclusive of the MA Child and Adolescent Needs and Strengths (CANS) tool must be completed prior to discharge.
3. Prior to discharge the provider convenes a final treatment (Family Team) meeting at which, with consent, e-copies of the youth's current treatment/transition and risk management/safety plans are distributed to all participants. The plans include documentation of all identified providers with contact information and dates of scheduled appointments or visits, a list of all currently prescribed medications and dosages, and documentation of ongoing strategies, supports, and resources to assist the youth in sustaining gains made as part of TCU.
4. The TCU provider is responsible for immediate notification to the MCE at the time of discharge.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.